Timothy G. Mahoney, DDS

CONFIDENTIAL INFORMATION QUESTIONNAIRE

*** NOTE: PARENTS OR GUARDIANS - if you are filling out this questionnaire for a child, please list yourself in spouse area below.** *Please Print*

PATIENT'S NAME LAST	FIRST	MIDDLE	DATE OF BIRTH D M Y	SEX

PATIENT'S ADDRESS STREET	APT #	CITY	PROV	POSTAL CODE	HOME PHONE

E-MAIL ADDRESS	ALBERTA HEALTH CARE #	CELL PHONE

PATIENT'S EMPLOYER	OCCUPATION	WORK PHONE

MARITAL STATUS ☐ M ☐ C ☐ S ☐ W ☐ D	SPOUSE'S NAME LAST	FIRST	MIDDLE	DATE OF BIRTH D M Y

SPOUSE'S EMPLOYER	OCCUPATION	WORK PHONE	CELL PHONE

EMERGENCY PERSON WE CAN CONTACT (OTHER THAN YOUR FAMILY HOME)

NAME WORK PHONE HOME PHONE

NAMES OF OTHER FAMILY MEMBERS THAT ARE PATIENTS HERE	HOW DID YOU FIND OUT ABOUT US?

INSURANCE AND FINANCIAL INFORMATION

Do you have dental coverage? _____

Please give information at front desk.

RELEASE

I am financially responsible for any balances due. I authorize the dentist to release any information required for my dental insurance claim. I authorize that my records can be used by the doctor if he so determines.

In consideration of the service rendered to me by this dental office I am obligated to pay said office in accordance with its credit terms and policy.

I consent to the taking of photographs and x-rays before, during and after treatment, and to the use of same by the doctor in scientific papers or demonstrations.

I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

Signature _____ Date _____